

WNYCCP

Western New York Care Coordination Program

The Western New York Care Coordination Program is a collaborative initiative by six County governments, the New York State Office of Mental Health, providers and consumers to transform community services systems serving people diagnosed with serious mental illness. The goal of the program is to create systems that are responsive to the interests of consumers, ensure access to high quality services, and promote recovery. Service delivery is based upon an individual services plan developed in partnership with consumers and their families.

The program is led by a Steering Committee that includes representatives of all participating governmental units, providers, and, most importantly, consumers. Project management is provided by Coordinated Care Services, Inc. (CCSI), a non-profit management services organization.

An inter-related set of programmatic, clinical, regulatory, fiscal, and technical initiatives are being implemented over a period of years. This approach allows us to learn from experience as we work to fundamentally change the culture and financial structure of the system to one that promotes person centered service planning, coordination of services, implementation of best practices, and accountability based on individual outcomes and consumer satisfaction.

The Steering Committee identified culture change as the critical first step to system transformation. This begins with the composition of the Committee and its collegial approach to development and implementation of the program. A major initiative is education and training programs in all participating counties for all participating providers and consumers about the principles of person centered planning, consumer directed care, and recovery.

Stakeholders

The Western New York Care Coordination Program is a collaborative effort of the New York State Office of Mental Health; Chautauqua, Erie, Genesee, Monroe, Onondaga and Wyoming counties; peers and family members; and outpatient mental health service and support providers.

Implementation Structure

Project Level

The work of the WNYCCP is directed by a Steering Committee composed of 11 voting members (5 county representatives, 3 peers/family members, and 3 providers) and 2 non-voting representatives from the NYS Office of Mental Health. A Peer and Family Advisory Group, which includes 2 representatives from each of the 6 participating counties, provides input to the Steering Committee, and proposes the 3 individuals from its membership who will hold the voting positions on the Steering Committee. Subcommittees and workgroups address both on-going and more time-limited subject areas; membership on these groups

includes both Steering Committee members and representatives from the larger stakeholder community. The Steering Committee makes decisions at the policy level regarding the Program's values, goals, objectives and initiatives. Implementation decisions are made at the county level.

The Co-Chairs of the Steering Committee are Michael Weiner, MBA, MS, Erie County Commissioner of Mental Health, and Kathleen Plum, RN, PhD, Monroe County Commissioner of Mental Health. Project management is provided by Coordinated Care Services, Inc. (CCSI), a non-profit management services organization. The full time staff includes Adele Gorges, Project Director, and Brian Phillips, Peer and Family Coordinator. Consultants include Paul Litwak, Esq., who advises the project on program design and development as well as legal matters, and the Blessing/Meissner Consulting Group, who are principally responsible for education and training programs about person centered services planning.

County Level

The Director of Community Services of each participating county takes the lead in implementation of WNYCCP initiatives in that county. Each county has a local advisory group, including consumers and providers, who work with the County Mental Health Department to implement the program.

Planning Process

A long term Project Level Plan was developed by the Steering Committee over a period of two years.

Each participating county has developed its own County Level Plan, including enrollment timelines and procedures, and specific implementation plans for the identified clinical, regulatory, fiscal and technical initiatives.

Change Principles

The Steering Committee formulated the following change principles to guide the Program:

- The WNYCCP is a multi-stage, multi-faceted effort to enhance the performance and accountability of community mental health systems.
- Outcomes will be closely monitored during each phase of development and improvements will be made based on actual performance.
- This gradual process will provide for major business and clinical change over time without disrupting existing service systems or requiring financial risk.

Goals and Objectives

Program goals include:

- Alignment of the interests of providers and consumers based on the principles of person-centeredness, person-centered planning and recovery.
- Empowerment of recipients through individual service planning that promotes choice.
- Coordination of services delivered by multiple providers.
- A rehabilitation and recovery model of services.
- Implementation of evidence-based best practices.
- Allocation of resources based on individual need.
- Improved information systems that provide timely, useful information
- Performance measured by outcomes
- Increased accountability

Clinical Initiatives

Following are summaries of the major, current, clinical initiatives.

1. Care Coordination

Each participating county has a “Single Point of Access” process which links to a variety of care coordination programs including Programs of Assertive Community Treatment (PACT) and Intensive Case management (ICM). Care coordinators differ from traditional case managers by their added authority to: (i) help recipients develop an Individual Services Plan (ISP), (ii) ensure consistency between the ISP and treatment plans developed by providers, (iii) coordinate crisis response, and (iv) access a pool of funds available to purchase non-traditional services or programs needed to support individuals in their recovery.

2. Culture Change

Despite the care taken to develop a template for individual service planning that focused on the interests of individual recipients, a review of the first set of Individual Services Plans developed by Care Coordinators revealed little change from the “provider knows best” case management system. Consequently, the philosophy and technology of person-centered planning, which had been developed within the developmental disabilities field, was identified as an approach that might be adapted to the adult mental health field. Person-centered planning is a family of tools and approaches designed to ensure that the priorities of the individual and those who support them form the basis for individualized plans leading to rehabilitation, recovery and community inclusion. Person-centered planning addresses not only the centrality of the individual’s goals, but also the role of systems and communities in supporting achievement of these goals.

An intensive training initiative was put together with the help of individuals experienced in person-centered planning. Two tracks were planned. One was for Care Coordinators or “practitioners and supervisors” of what would become “person-centered care coordination”. The second track targeted community mental health providers and focused on development

of organizational support for the cultural change of person centered care coordination. In the course of 2003, the training was expanded to include clinicians, psychiatrists and enrollees in the WNYCCP.

The Program continues to work towards cultural change in 2004 by (i) implementing “train-the-trainer” programs, (ii) training clinical staff who work in Personalized Recovery Oriented Services (PROS) programs, to be licensed by the NYSOMH in 2004/2005, and (iii) providing orientation for WNYCCP enrollees who will be participating in person-centered planning with Care Coordinators or PROS staff.

We intend to “institutionalize” these training initiatives by developing a formal curriculum and set of training materials as well as a video that introduces the Care Coordination program and explains and illustrates the principles of person-centered service planning.

3. Family Education and Support

The WNYCCP was chosen to participate in a state-wide initiative to provide training to agencies interested in providing a family education and support service, one of the identified evidence-based practices. The network and training structure developed to support the introduction of person-centered planning is being used to support this initiative. In addition, the NYS Office of Mental Health identified a model which would allow them to use the resources traditionally needed to train 4 agencies or affiliated providers to instead train all interested providers in 6 counties. While still in the early stages of implementation, there will be up to 21 agencies participating across the 6 counties.

4. PROS Plus

With the introduction of a new license for Personalized Recovery Oriented Services (PROS) in New York State, the WNYCCP is formulating principles and guidelines for a PROS program within the context of the WNYCCP. They seek to foster (i) a single, simplified system for PROS provider and the Care Coordination programs with which they work, and (ii) a PROS system that incorporates the same benefits to consumers as are being pursued within the WNYCCP. (See Attachment: “PROS Plus” Principles and Guidelines)

5. Improved integration between medical and behavioral health services

The Steering Committee is working with medical providers in participating counties to develop initiatives to improve access to physical health services and coordination of physical and mental health services to participating consumers. This may include implementation of best practices, such as protocols for treatment of diabetes developed at the University of Illinois-Chicago. WNYCCP is in a unique position to test and report on the impact of these efforts. The New York State Office of Mental Health has access to Medicaid claims data and CCSI has the ability to conduct statistical data analysis. It is worth noting that interest in this research has been expressed by faculty of two area universities.

Regulatory Initiatives

1. Regulations

The New York State Office of Mental Health approved certain waivers in regulations governing licensed outpatient programs to give providers participating in the Care Coordination Program greater flexibility to implement a rehabilitation and recovery model of service. This includes:

- Flexible use of program staff and space
- Permission to co-enroll individuals in multiple programs, promoting enrollees choice and flexibility in building service plans, and avoiding “locking” individuals to a single provider.
- Elimination of restrictions on number of intensive psychiatric rehabilitation treatment visits;
- Expansion of the types services that may be reimbursed by Medicaid, allowing providers to offer more non-traditional services to help individuals in their recovery.
- Greater flexibility in creation of satellite locations to improve outreach to recipients.
- An expedited licensing process

2. Contracts

The Steering Committee developed model contracts between counties and participating providers. The agreements describe the role and responsibilities of different types of providers relative to the Care Coordination program. They share the common themes of priority access for program participants, cooperation with Care Coordinators and other providers of service, participation in the development and review of Individual Service Plans (ISP), development of treatment plans consistent with ISP's, and cooperation with performance management and outcomes measurement efforts.

3. Personalized Recovery Oriented Services (PROS) Provider Licenses

As previously indicated, New York State has developed a new Personalized Recovery Oriented Services license. In the six WNYCCP counties, this license will be implemented within the context of the WNYCCP. (See Attachment: “PROS Plus” Principles and Guidelines).

Fiscal Initiatives

The Steering Committee developed and the New York State Office of Mental Health approved a “Simulated Case Payment” system to enable Counties and Care Coordinators to access a pool of funds to be used to: (i) help recipients acquire programs, services or natural supports needed to help them in their recovery, (ii) support education and training of providers and consumers, and (iii) help providers transition from “program-centered” funding to “person-centered” funding approaches.

In Phase 3 of Care Coordination Program, we will continue our effort to eliminate structural barriers to recipient centered recovery and service coordination by developing Home and Community Based Waiver or other financial models that allow pooling of Medicaid and other available funds to create a “single checkbook” to be used to purchase services identified in Individual Services Plans. The ultimate result may be a capitation based funding system. But we want the design of the financing system to reflect our experience implementing fundamental changes in culture and program design. We believe this is a better long-term approach than forcing complex human service systems to adapt to a financial model.

Technical Initiatives

Accountability will be achieved through systematic monitoring of key indicators of the individuals well being and safety, housing, employment, access of services, criminal justice system involvement, satisfaction, and service utilization. Performance outcomes will be monitored throughout the implementation and operation, allowing counties to make adjustments based on real life experience.

Data will be collected through a number of sources, including Medicaid claims, annual satisfaction surveys, tools developed specifically for the collection of data regarding care coordination, and survey instruments developed for individual initiatives, such as the Survey of Individual Service Plans for Year One Indicators of Person-Centered Planning.

The Steering Committee is working with the NYS Office of Mental Health in an effort to adopt the Child and Adult Integrated Reporting System (CAIRS), the information system developed to support the Single Point of Access initiative to accommodate collection of performance management data.

A website, www.carecoordination.org, informs the public about the program, and supports communication among stakeholders. We are working to develop a county-by-county inventory of services available to program participants. This service directory will be “service based” rather than “program based”. The service directory will be posted on the website and will be searchable, to inform consumers and care coordinators and support client choice. We are working with a number of stakeholders to improve enrollee access to the Internet.

Project Time Line

Stage 1 – 2001 - 2002

- Initial program design
- Development of Steering Committee
- Staffing
- Identification of desired waivers of State regulations and State approval of those waivers
- Development of model Individual Services Plan (ISP)

- Development of Performance Management Indicators
- Piloting of model ISP and performance indicators
- Negotiation of Data Sharing agreements with Single State Medicaid Agency
- Work towards systems for capture of data required for performance management
- Design of education and training programs
- Development of contract models
- Initial enrollment

Stage 2 – 2003 and 2004

- Learn from stage 1 experience
- Person-centered planning training
- Design of approach for integration of Care Coordination with the NYS PROS initiative - “PROS Plus”
- Expansion of eligible population to include PROS recipients
- Design of program for enhanced integration of physical and mental health services, implementation of best practice, and monitoring of results
- Exploration of “single checkbook” funding options
- Begin capture of performance data.
- Initial studies of program performance
- Initial implementation of evidence-based practices – Family Education and Support

Stage 3 – 2004 and 2005

- Possible expansion of program to include additional counties.
- Continued exploration of funding models that will further program goals
- Implementation of physical/mental health program.
- Specific design for “single checkbook” financing system.
- Work towards county, state and federal government approval of “single checkbook” system. May require Medicaid waivers.
- Design of financial risk allocation model to support possible capitation based financing.
- Identification of resources required to implement a capitation based system (akin to managed care organization or health benefit plan).
- Full implementation of MIS systems used to capture and analyze performance management data.

Enrollment

Enrollment commenced in July 2002. It stood at 1202 as of December 31, 2003. It is projected to be 1801 at the end of 2004, and approximately 2600 by the end of 2005.

Performance Management

A full performance indicator grid, including data sources and report types and frequencies, has been developed. While many of the elements of the complete system are still being put into operation, some initial data has been collected and is reported below. Of interest is the consistency of the information, not only among these sources, but also in relationship to the findings from enrollee focus groups held in two of the WNYCCP counties.

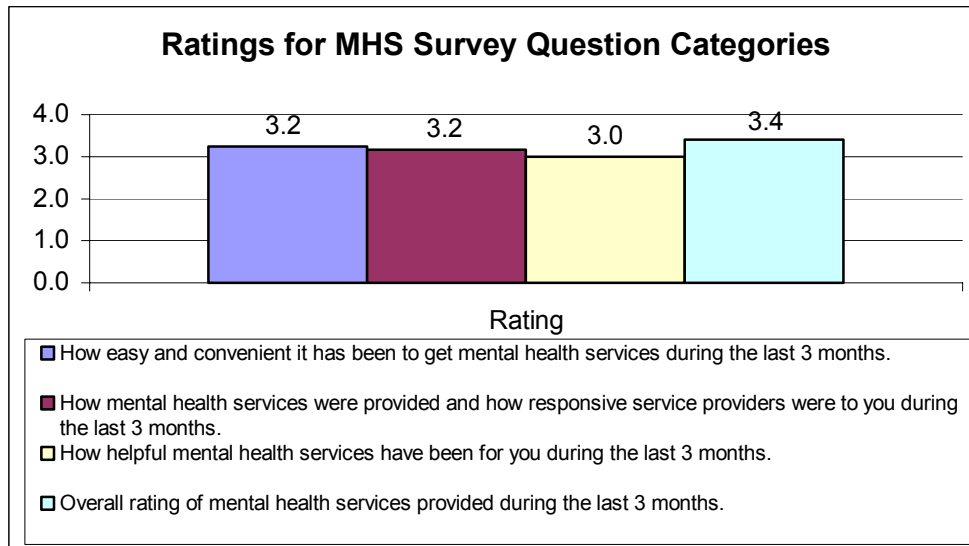
1. Survey of Individual Service Plans for Year 1 Indicators of Person-Centered Planning

Training in person-centered planning began in April, 2003, with Care Coordinators and their supervisors spending an average of two days per month learning new approaches and tools. In September 2003, 10% of the Individual Service Plans and associated documents for WNYCCP enrollees were surveyed for six indicators of person-centeredness and person-centered planning, on a four point scale. The survey results were as follows:

Item #	Indicator	Average Score
Item 1	The person's (enrollee's) dreams, interests, preferences, strengths and capacities are explicitly acknowledged and drive activities, services and supports.	2.5
Item 2	Services and supports are individualized and don't rely solely on pre-existing models	2.6
Item 3	The person has a presence in a variety of typical community places. Segregated services and locations are minimized.	2.4
Item 4	Planning activities occur periodically and routinely. Lifestyle decisions are revisited.	2.2
Item 5	A group of people who know, value and are committed to the person remains involved.	1.8
Item 6	There are steps towards tangible changes in areas where the person is dissatisfied.	95%

2. Enrollee Satisfaction Survey

In November 2003, WNYCCP enrollees were surveyed using the Mental Health Satisfaction Survey instrument developed by the NYS Office of Mental Health. The survey addressed overall satisfaction with the service system. Overall, the ratings were good:

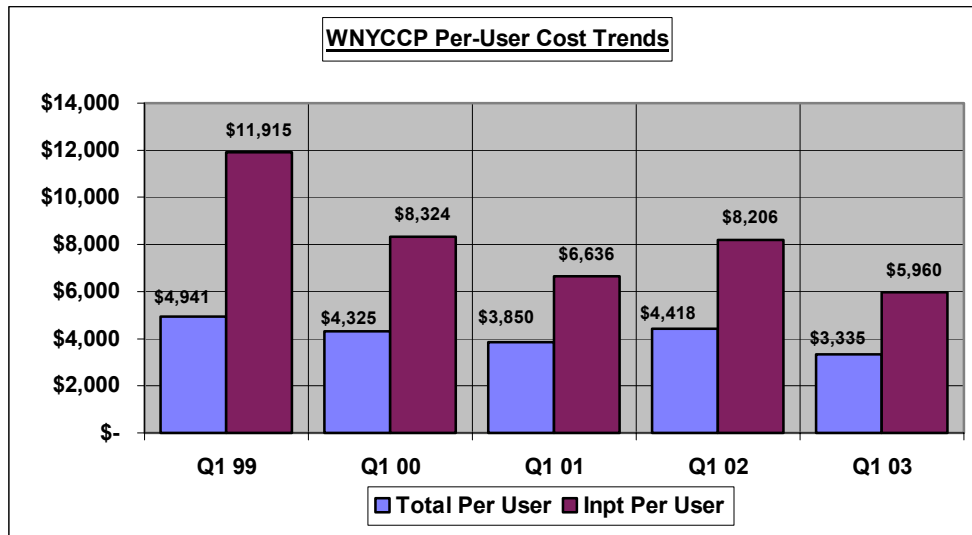


The specific questions with the highest and lowest scores indicated areas for future focus for the WNYCCP:

- Enrollees gave the highest ratings to
 - Helpfulness, cultural competence and respectfulness of care coordinators and therapists
 - Range, accessibility and overall quality of services
- Enrollees gave the lowest ratings to
 - Information provided about diagnosis, treatment and medication
 - Efficacy of medication in reducing symptoms
- Helpfulness of services in relation to work, school, daily problems, dealing with others, ability of manage in a crisis

3. Medicaid Claims Data Analysis

An analysis was done of Medicaid claims for 406 individuals enrolled in the program in the first quarter of 2003, comparing both total cost per user and inpatient cost per user for the first quarter of 1999, 2000, 2001, 2002 and 2003.



The initial impact on the cost of care has been significant, as illustrated above. During the first quarter of 2003, the total average cost per enrollee for all services was 32% less than during the first quarter of 1999, and during the same time period, the total average cost per enrollee using inpatient services declined by 50%.

Contact Information

- Steering Committee Co-Chair
Michael Weiner, MBA, MS
Erie County Commissioner of Mental Health
 - 716-858-8531
 - weinerm@erie.gov
- Steering Committee Co-Chair
Kathleen Plum PhD, RN
Director, Monroe County Office of Mental Health
 - 585-274-6047
 - kplum@monroecounty.gov
- Project Director, Adele Gorges
 - 585-613-7656
 - agorges@ccsi.org
- Peer and Family Coordinator, Brian Phillips
 - 585-613-7653
 - bphillips@ccsi.org
- Website:
www.carecoordination.org

Attachment 1

“PROS PLUS” PRINCIPLES AND GUIDELINES

The PROS initiative presents an exciting opportunity to advance many of the goals being pursued through the Western New York Care Coordination Program. Accordingly, the six counties participating in the Western New York Care Coordination Program (WNYCCP) and the New York State Office of Mental Health have agreed that PROS will be implemented within these counties in the context of the WNYCCP (“PROS Plus”). These guidelines outline what this means for a PROS Plus provider. These guidelines are intended to foster (1) a single, simplified system for PROS providers and the Care Coordination programs with whom they work and (2) a PROS system that incorporates the same benefits to consumers as they are being pursued within the WNYCCP. The core principles are:

Person Centeredness: The relationship between PROS providers and the persons they serve is based on the principles of person-centeredness, person-centered planning and recovery.

PROS Service Structure: Planning and service delivery are based on the person-centered planning philosophy and utilize person-centered planning tools and methodologies. The PROS program is recovery oriented, values client choice, and promotes the use of natural supports. Hours of attendance are flexible rather than fixed and reflect the individual’s choices from a menu of available services that include services delivered by peers. PROS Plus providers fully commit to training in person-centered planning for both staff and people enrolled in PROS.

Organizational Culture: The organizational culture promotes recovery and rehabilitation, reflects a commitment to person-centered planning and individualized, flexible use of resources, considers all workers to be part of a team, and commits to employees (including peer employees) having access to resources to maintain their unique skills. PROS providers engage in organizational development to align their organizations by eliminating organizational barriers to person-centered approaches.

Integration of Care Coordination with PROS: For WNYCCP enrollees, PROS providers plan and delivery services based on the Individual Service Plan developed by the consumer with the Care Coordinator. PROS providers insure integrated services and recovery planning by, among other things, using cascading documentation (consistent with the model forms packet being developed) for clients who have a Care Coordinator and are receiving services from a PROS provider. The PROS provider will communicate effectively with the consumer and Care Coordinator to insure coordinated services consistent with the individual’s expressed needs and interests.

Evidence-Based Practices: PROS providers will implement evidence-based practices and best practices, including those identified by the County.

Performance and Outcomes Management: PROS providers will participate in County performance management initiatives. These initiatives will include performance management indicators developed by the Western New York Care Coordination Program. PROS providers will participate in training that may be necessary in conjunction with the County performance management initiatives.